DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **EXPIRED/BROKEN CONTROLLED DRUG PHARMACY REPORTING FORM** REFERENCE NO. 702.1

1. Provider Agency _____ Unit number_____

2. Request for exchange of **EXPIRED** drugs:

Drug	# of syringes or equivalent	Strength	Total
Fentanyl			mcg
Midazolam			mg
Morphine Sulfate			mg

3. Request for replacement of **BROKEN** drugs – **Broken container must accompany this request**

Drug	# of syringes or equivalent	Strength	Total
Fentanyl			mcg
Midazolam			mg
Morphine Sulfate			mg

4. Date and time narcotic was noted broken: __/__/__ @ __:__

5. Print name and title of individual(s) who discovered the broken narcotic:

_____ _____

_____ _____

7. Print name/title of person completing this form _____

Signature _____ Date completed: ___/___/___

8. Paramedic Coordinator's signature _____

FOR PHARMACY USE ONLY

Replaced: Fentanyl # of syringes or equivalent: _____ Total mcg:_____
Midazolam # of syringes or equivalent: _____ Total mg: _____
Morphine Sulfate # of syringes or equivalent: _____ Total mg: _____

Pharmacist: _____ Date: _____ Time: _____